PATIENT INFORMATION Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Gender: M / F Marital Status: M S D W Email Address: _____

Name of Spouse or Nearest Relative: _____ Phone: _____

How did you hear about our office?: _____ SS# _____-_____-_____

Are you under hospice care? Yes/No Have you ever smoked tobacco? Yes/No If yes, How long? ___

FAMILY MEDICAL HISTORY PLEASE CIRCLE **M for Mother's family** **F for Father's family**

M/ F Cancer **M / F S**troke **M/ F** Seizures **M / F** High blood pressure

M/ F Back pain **M/ F** Heart disease **M/ F** Diabetes **M/ F** Epilepsy

MEDICAL HISTORY

___allergies	___dislocations	___muscular dystrophy	___anemia
___epilepsy	___liver problems	___ kidney disorders	___asthma
___headaches	___neck pain	___rheumatic fever	___back pain
___heart trouble	___measles	___HIV/AIDS	___polio
___rheumatoid arthritis	___bladder trouble	___high blood pressure	___cancer
___poor circulation	___concussion	___convulsions	___bowel control loss
___scarlet fever	___serious injury	___sinus trouble	___indigestion
___multiple sclerosis	___thyroid issue	___Alzheimer's	___Parkinson's
___bone fracture	___diabetes	___numbness	___tuberculosis

Have you been treated by a physician for any health condition in the last year? Yes /No

Describe condition: _____ Date of last physical exam: _____

Who is your Primary Care Physician: _____ Clinic:_____

MAJOR SURGICAL HISTORY

1)_____ Date:_____

2)_____ Date:_____

3)_____ Date:_____

4)_____ Date:_____

5)_____ Date:_____

ACCIDENT HISTORY

___Job ___Auto ____ Other 1)_____ Date: _____

___Job ___Auto ____ Other 2)_____ Date: _____

___Job ___Auto ____ Other 3)_____ Date:_____

MAJOR COMPLAINTS

Complaint: 1)_____

Complaint: 2)_____

Complaint: 3)_____

Symptoms are worse in the: *Morning* _____ *Afternoon* _____ *Night* _____

How did your symptoms develop? ___ Job related ___ Auto accident ___ Illness ___ Unknown

Date occurred: _____

Are you allergic to any medications? NO /YES Please list : _____

Are you currently taking any medications? NO /YES

Please list dose and frequency:

_____

_____

_____

_____

Are you pregnant? ___No Last Cycle: _____ ___Yes Due date: _____

Please check the following activities that aggravate your condition:

____Bending ____Reaching ____Straining @ Stool ____Coughing ____Turning head

____Lifting ____Sneezing ____Walking ____Standing ____Lying down ____Sitting

Please c heck the following activities that relieve your condition:

____Bending ____Reaching ____Turning head ____Lifting

____Walking ____Standing ____Lying down ____Sitting

Please check any additional symptoms you may be experiencing:

___Blurred vision	___Insomnia	___Buzzing in ears	___Sensitive to light
___Cold feet/hands	___Loss of balance	___Cold sweats	___Loss of taste
___Stiff neck	___Muscle jerking	___Headaches	___Constipation
___Numbness in fingers	___Ringing in ears	___Diarrhea	___Shortness of breath
___Dizziness	___Confusion	___ Flushed Face	___Indigestion
___Fatigue	___Depression	___Weeping Spells	___Fever
___Head feels heavy	___ Muscle Spasms	___Joint Cracking	___Numbness in toes

Compass Medical Center

This office makes every possible attempt to maintain patient privacy as per HIPPA (1996).

APPOINTMENTS: Patients are seen by appointment. For urgent and acute situations, we often schedule "work-in" appointments. Work-in appointments are made to address one acute problem, only so that patients with scheduled appointments are not kept waiting. We apologize in advance for any unforeseeable delay you may experience. If you are more than 15 minutes late for your appointment, you will be asked to reschedule. Cancellations must be made 24 hours prior to your appointment.

We charge $25.00 for missed appointments.

SOCIAL SECURITY NUMBERS: We handle patient social security numbers and personal information in a confidential manner, but we may release personal and medical information to another doctor's office in the event of a referral. We use social security numbers for insurance and billing purposes. This is required information that we ask from each of our patients.

MINORS: All children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave child unattended in the waiting area. A staff member will always be available to sit with your child during your treatments if needed.

PAYMENT: Payment is due from each patient at the time of service. We accept several different kinds of payment options. We gladly accept cash, check, Visa, Master Card, Discover, HSA, HRA, and Care Credit.

INSURANCE: We participate with several major insurance carriers. Our office policies concerning the deductible and HSA/HRA plans are as follows: Patients are responsible for their coinsurance, deductibles, and co pays in full. Payment is due at the time of service and is based on the patient's insurance company's contracted rates.

ACKNOWLEDGEMENT: I have read, understand, and agree to follow the above office policies.

Patient / Guardian Signature:_____ Date:_____

Printed Name of Patient:_____